About The American Institute of Balance

- The Institute is the country's largest specialty practice in Audiology, Balance, Vestibular Evaluation and Treatment. Established in 1992, the Institute has provided over 50,000 evaluations for the areas leading ear, nose and throat, neurology, and primary care physicians.
- The Institute is an academic and clinical training facility for the University of South Florida, University of Florida, and Nova Southeastern University.
- The Institute provides comprehensive evaluation for pediatric through geriatric populations.
- The Institute offers five Videonystagmography diagnostic technologies, as well as Kinetic Rotary Chair and Vestibular Autorotational Testing, to ensure the patient's maximum comfort and evaluation validity.
- Richard E. Gans, Ph.D., The Institute's Director, is an internationally recognized author and researcher in vestibular disorders and treatment.
- The Institute's professional staff is comprised of a Ph.D. and two Doctors of Audiology (Au.D.). All are licensed by the State of Florida and are board certified by the American Board of Audiology.

Participating Providers for:
Medicare Part B, Health Options, AARP Secure Horizons, Av-Med, United HealthCare, Medicare Advantage Plans, Champus-TriCare, Humana, and Well Care, All Aetna products, CarePlus Health Plans, Universal Health Care

Scheduling:
Please call our central scheduling line for all Institute locations at **727.398.5728 or toll free at 1.800.245.6442. Fax: (727) 398-4914**

Institute locations:
Main Office:
8200 Bryan Dairy Rd., Suite 340, Largo FL 33777

New Port Richey:
5515 Gulf Drive, Suite A , New Port Richey, FL 34652

Welcome to The American Institute of Balance

The Institute was founded in 1992 and is among the country's largest multi-specialty centers for the evaluation and treatment of dizziness and balance disorders. The Institute is nationally and internationally known for its expertise in evaluation, treatment and rehabilitation. The Institute's therapy programs are used by physicians, audiologists and therapists worldwide.

What to Expect at your Appointment

Your visit will include a variety of simple but technically advanced tests using computers and highly specialized equipment not available in most medical centers. There will be no pins or needle sticks. Your appointment will last 60 – 90 minutes.

Prior to each test an explanation will be given so that you will have a better understanding of what is being tested and why. We make every attempt to make your visit comfortable as well as educational.

We will be sure to discuss the results whenever possible and send all results to your referring physician.

DOs and DON'Ts

So we can obtain accurate results, we ask that you please review the following instructions carefully:

1. Do not wear any makeup, including mascara, eye liner, or face lotions. These products might interfere with the recordings.

2. Do not drink alcoholic beverages for 48 hours before the test.

3. Certain medications can influence the body's response to the test, thus giving a false or misleading result. If possible, please refrain from taking the following medications for 48 hours prior to your appointment. **Anti-vertigo medicines**: Anti-vert, Ru-vert, or Meclizine; **Anti-nausea medicine**: Atarax, Dramamine, Compazine, Antiver, Bucladin Phenergan, Thorazine, Scopalomine, Transdermal.

4. Vital medications SHOULD NOT be stopped. Continue to take medications for heart, blood pressure, thyroid, anticoagulants, birth control, antidepressants, and diabetes. If you are unsure about discontinuing a particular medication, please call your physician to determine if it is medically safe for you to be without them for 48 hours.

5. Eat lightly the day of your appointment. If your appointment is in the morning you may have a light breakfast such as toast and juice. If your appointment is in the afternoon, eat a light breakfast and have a light snack for lunch.

6. Testing may cause a sensation of motion that may linger. If possible, we encourage you to have someone accompany you to and from the appointment. However, if this is not possible, try to plan your day to include an extra 15 to 30 minutes after your test before leaving the office.

Patient Instructions

You will be instructed to refrain from taking certain medications for 48 hours prior to your test date. Certain medications can influence the body's response to the test, thus giving a false or misleading result. You will find a short list below, however if you have any questions or concerns about discontinuing your medications please consult your doctor.

Alcohol: beer, wine, cough medicine. **Analgesics - Narcotics:** Codeine, Demerol, Phenaphen, Tylenol with codeine, Percocet, Darvocet. **Anti-histamines:** Chlor-trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Teldrin, Triaminic, Hismanol, Claritin .. any over-the-counter cold remedies. **Anti-seizure medicine:** Dilantin, Tegretol, Phenobarbital. **Anti-vertigo medicine:** Anti-vert, Ru-vert, Meclizine. **Anti-nausea medicine:** Atarax, Dramamine, Compazine, Antivert, Bucladin, Phenergan, Thorazine, Scopalomine, Transdermal. **Sedatives:** Halcion, Restoril, Nembutal, Seconal, Dalmane, or any sleeping pill. **Tranquilizers:** Valium, Librium, Atarax, Vistaril, Serax, Ativan, Librax, Tranxene, Xanex.

You ***may take blood pressure medications, heart medications, thyroid medication, Tylenol, insulin, estrogen, etc. Always consult with your physician before discontinuing any prescribed medication.

Please eat lightly for 12 hours prior to your appointment. If your appointment is in the morning you may have a light breakfast such as toast and juice. If your appointment is in the afternoon eat a light breakfast and have a light snack for lunch. *Please avoid caffeine in beverages such as coffee or soft drinks.*

Testing may cause a sensation of motion that may linger. If possible we encourage you to have someone accompany you to and from the appointment, however, if this is not possible try to plan your day to include an extra 15 to 30 minutes after your test before leaving the office.

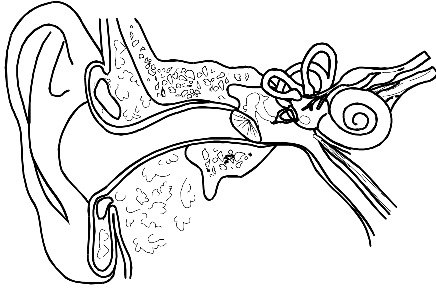
Your Time at the Institute

A comprehensive battery of tests will be performed during the two hour appointment allocated for you. Prior to each test an explanation will be given so that you will have a better understanding of what is being tested and why. We make every attempt to make your visit comfortable as well as educational.

Once your evaluation is completed each part is carefully evaluated and reviewed. This process is as important as your test, so please understand that your test results will not be discussed in detail at the time of your evaluation. Once the interpretation has been made a detailed report will be forwarded to you and/or your referring physician.

EVALUATING & TREATING EQUILIBRIUM DISORDERS

Dizziness, vertigo and unsteadiness are symptoms associated with the human equilibrium System and cannot be physically examined. Your physician will request any and/or all of The following studies to assist in the proper diagnosis.

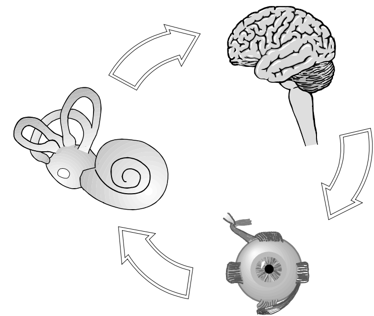


Audiologic, Immittance, & Oto-Acoustic Emissions

Balance disorders are often accompanied by changes is hearing or the ears function. A thorough evaluation begins with computer testing of the outer, middle and inner ears.

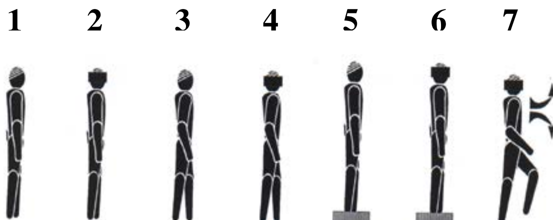
Electrophysiological Studies

- **Brainstem Auditory Evoked Potentials**
- **Electronystagmography**
- **Electrocochleography**
- **Electro-oculography**
- **Vestibulo Autorotation**



These sophisticated computer generated tests evaluate the inner ear pathways, the central nervous system, and the connections between eye movement and the brain.

Sensory Organization Performance



Normal balance requires the correct information from the balance center portion of the inner ear, the eyes and the pressure sensors in the feet, ankles, muscles and joints. This evaluates your postural stability. The eight sensory conditions isolate each of the three principle balance senses of vision, inner ear, and touch, and determines the function of each.

Treatment

Most balance problems can be treated medically, Surgically or with therapy once they have been Accurately evaluated. Rehabilitation therapy is now Successfully reducing or eliminating dizziness, vertigo And unsteadiness for many patients.

Patient Care • Education • Research

THE AMERICAN INSTITUTE OF BALANCE, INC.
SUMMARY OF PRIVACY POLICIES

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will:

Adhere to the standards set forth in the Notice of Privacy Practices.

Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.

Use and disclose PHI to remind patients of their appointments unless they instruct us not to.

Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will:

Implement reasonable measures to protect the integrity of all PHI maintained about patients. Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.

Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:

Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.

Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by law.

Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete.

Our practice and its physicians and staff will:

Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.

Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.

All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Richard E. Gans, Ph.D., 727.398.5728.**

THE AMERICAN INSTITUTE OF BALANCE, INC.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, ____________________, have received a copy of **AMERICAN INSTITUTE OF BALANCE'S**
Patient Name

Notice of Privacy Practices.

___________________________ ___________________
Signature of Patient Date

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PATIENT DETAILS

PERSONAL INFORMATION

Name:____ ☐ MALE ☐ FEMALE
First M. Last
Address:_______________________________________ Apt/Unit#: _____________ City__________________

State: _________ Zip Code: ______________ Home Phone:_________________________ Work Phone:____________________

Mobile Phone: _________________________ Email Address: ____

SS#:_____-_____-_____ Date of Birth: ____/____/_____ Age:_____ Marital Status: _________

IN CASE OF EMERGENCY, CONTACT:_______________________________ Phone:_________________

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

Employer:____
Address:____ City:____________________

State:____________________ Zip Code:_____________________

MEDICAL DOCTOR INFORMATION:

Referring Physician:____ Phone: ( ) ______-________

Address:_________________________________City:_________________ State:______ Zip Code:________

Family Physician:____ Phone: ( )_____-______

PLEASE STATE BRIEFLY THE NATURE OF YOUR PROBLEM:____
PLEASE LIST OPERATIONS YOU HAVE HAD:____
PLEASE NAME ANY MEDICATIONS YOU ARE ALLERGIC TO OR HAVE BEEN ADVISED NOT TO TAKE:____

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD OR CURRENTLY HAVE:

☐ Heart Disease	☐ Glaucoma	☐ Stroke	☐ Nausea	☐ Artificial Joints	☐ Ulcer Disease
☐ Depression	☐ Cancer	☐ Pacemaker	☐ Asthma	☐ Arthritis	☐ Back Problems
☐ Tuberculosis	☐ Diabetes	☐ Neck Problems	☐ Emphysema or COPD	☐ Infection/Wounds	☐ Blood Disorders
☐ Breathing Problems	☐ High Blood Pressure	☐ Parkinson's Disease	☐ Ringing In Ears	☐ Circulation Problems	☐ Epilepsy or Convulsions

Other:____

ACKNOWLEDGEMENT OF PAYMENT (CHECK ALL THAT APPLY)

☐ Cash ☐ Check ☐ Visa ☐ MasterCard ☐ Discover
☐Primary Insurance:_______________________________________ _________________________ ______________
Name of Insurance ID # Group#
☐Secondary Insurance:_______________________________________ _________________________ ______________
Name of Insurance ID # Group#

I understand that I am ultimately responsible for the balance on my account for any professional services rendered. I authorize your office to release any information relating to the services obtained here and those services related to my treatment here to other professionals and insurers as may become necessary. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services described.

AUTHORIZATION FOR TREATMENT

The patient /legal guardian authorized The American Institute of Balance staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.
Signature:____ Date:__________________________

PATIENT QUESTIONNAIRE

PATIENT NAME: ______________________________________ **DATE:** __________________

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur? ____

How long did it last? ____

I. Do you experience any of the following sensations? Please read the entire list first. Then put an 'x' in either the first box for YES or the second box for NO to describe your feelings most accurately.

YES	NO	
☐	☐	Do you experience motion, air or sea sickness?
☐	☐	Did you have motion sickness as a child?
☐	☐	Do you have a family history of motion sickness? parent?____sibling?____child?____
☐	☐	Do you have migraine headaches?
☐	☐	Were you exposed to any solvents, chemicals, etc.?
☐	☐	Did you have any injuries to your head? When? ___________________
☐	☐	If you received a head injury, were you unconscious?
☐	☐	Have you ever had a neck injury?
☐	☐	Have you ever fallen? How many times? _______ Where? __________ Inside the home? _____ Outside the home? _____
☐	☐	Are you afraid of falling?
☐	☐	Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics, thyroid) What? ______________
☐	☐	Do you use alcohol?

II. If you have dizziness, please check the box for either YES or NO, and fill in the blank spaces. If you do not experience dizziness, please go to the next section (III).

YES	NO	
☐	☐	My dizziness is constant? If you answered yes, please go to section III.
☐	☐	If in attacks, how often? ______________________________________
☐	☐	Are you completely free of dizziness between attacks?
☐	☐	Do you have any warning that the attack is about to start?
☐	☐	Is the dizziness provoked by head/body movement? If so, which direction?_____________
☐	☐	Is the dizziness better or worse at any particular time of the day? If so, when? ____
☐	☐	Do you know of anything that will stop your dizziness or make it better? What? ____
☐	☐	……………………………………make your dizziness worse? What? ____
☐	☐	……………………………………precipitate an attack? What? ____
☐	☐	Do you know any possible cause of your dizziness? What? ____

PATIENT NAME: ____ **DATE:** __________________

III. Do you experience any of the following sensations? Please read the entire list first then please check the box for either YES or NO to describe your feelings most accurately.

YES	NO	
☐	☐	Light headedness?
☐	☐	Swimming sensation in the head?
☐	☐	Blacking out or loss of consciousness?
☐	☐	Objects spinning or turning around you?
☐	☐	Sensation that you are turning or spinning inside, with outside objects remaining stationary?
☐	☐	Tendency to fall………. to the right or left.
☐	☐	…………………………. forward or backward
☐	☐	Loss of balance when walking….. veering to the right?
☐	☐	……………………………………. veering to the left?
☐	☐	Do you have trouble walking in the dark?
☐	☐	Do you have problems turning to one side or the other?
☐	☐	Nausea or vomiting?
☐	☐	Pressure in the head?

IV. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or if In Episodes.

YES	NO			
☐	☐	Double vision?	Constant	In Episodes
☐	☐	Blurred vision or blindness?	Constant	In Episodes
☐	☐	Spots before your eyes?	Constant	In Episodes
☐	☐	Numbness of face, arms or legs?	Constant	In Episodes
☐	☐	Weakness in arms or legs?	Constant	In Episodes
☐	☐	Confusion or loss of consciousness?	Constant	In Episodes
☐	☐	Difficulty in swallowing?	Constant	In Episodes
☐	☐	Tingling around the mouth?	Constant	In Episodes
☐	☐	Difficulty speaking?	Constant	In Episodes

V. Do you have any of the following symptoms? Please check the box for either YES or NO and circle the ear involved.

YES	NO				
☐	☐	Difficulty in hearing?	Both Ears	Right Ear	Left Ear
		When did this start? ___________________ Is it getting worse? _______________			
		Does the hearing change with your symptoms? If so, how? ________________			
☐	☐	Noise in your ears?	Both Ears	Right Ear	Left Ear
		Describe the noise? ____			
		Does the noise change with your symptoms? If so, how? ____________________			
☐	☐	Does anything stop the noise or make it better? ____________________________			
☐	☐	Fullness or stuffiness in your ears?	Both Ears	Right Ear	Left Ear
		Does this change when you are dizzy? ___________________________________			
☐	☐	Pain in your ears?	Both Ears	Right Ear	Left Ear
☐	☐	Discharge from your ears?	Both Ears	Right Ear	Left Ear